Application to Use Burden/Hours from Generic PRA Clearance:
Medicaid and CHIP State Plan, Waiver, and Program Submissions
(CMS-10398, OMB 0938-1148)

Information Collection #52 Delivery System and Provider Payment Initiatives Under Medicaid Managed Care Products

Center for Medicaid and CHIP Services (CMCS)
Centers for Medicare & Medicaid Services (CMS)

Note: This 2020 iteration adds two examples that support our currently approved pre-print: Appendix K and COVID19. They are needed in order to facilitate CMS' expedited review and approval of these state-directed payments that states are seeking approval to add to their managed care contracts in response to the COVID-19 public health emergency. Please note that we are not proposing any changes to the currently approved pre-print except for updating the PRA Disclosure Statement.

We are also adding a CMCS Information Bulletin (hereinafter, "CIB" or "Bulletin"). The Bulletin outlines CMS' framework to provide flexibility appropriate to the public health emergency, while still maintaining alignment with statutory and regulatory requirements on the use of state-directed payments, including that managed care capitation rates must still be actuarially sound, and that payments under managed care contracts must still maintain linkages to utilization delivered under the contract.

These two preprint examples are intended to assist states by providing examples of preprint submissions for states wanting to require their managed care plans to pay:

1. *Appendix K example - retainer payments that the state has obtained authority to make as part of their 1915(c) HCBS waiver, section 1115 demonstration, or other CMS authority.*
2. *COVID – 19 example – payments to providers to help mitigate the impacts o the public health emergency.*

We are also revising our cost estimates based on more recent BLS wage data. We are not revising any of our time estimates.

A. Background

The Centers for Medicare & Medicaid Services (CMS) work in partnership with States to implement Medicaid and the Children's Health Insurance Program (CHIP). Together these programs provide health coverage to millions of Americans. Medicaid and CHIP are based in Federal statute, associated regulations and policy guidance, and the approved State plan documents that serve as a contract between CMS and States about how Medicaid and CHIP will be operated in that State. CMS works collaboratively with States in the ongoing management of programs and policies, and CMS continues to develop implementing guidance and templates for States to use to elect new options available as a result of the Affordable Care Act or to comply with new statutory provisions. CMS also continues to work with States through other methods to further the goals of health reform, including program waivers and demonstrations, and other technical assistance initiatives.

B. Description of Information Collection

We will require states to submit a section 438.6(c) preprint for state-directed expenditures under an MCO, PIHP, or PAHP contract for delivery system and provider payment initiatives in Medicaid managed care. This preprint will be used to meet the prior approval requirement under §438.6(c)(2)(i). The preprint specifies our requirements for prior approval, including the requirements under §438.6(c)(2)(i)(A) through (F), and the requirements under §438.6(c)(2)(ii)

(A) through (D). These requirements specify that states must obtain written approval prior to implementation of the state-directed payment arrangement.

This collection is required per our regulations at §438.6(c)(2)(i), which requires that states obtain written approval prior to implementation of the state-directed payment arrangement.

C. Deviations from Generic Request

No deviations are requested.

D. Burden Hour Deduction

The total approved burden ceiling of the generic ICR is 154,104 hours, and CMS previously requested to use 116,020 hours, leaving our burden ceiling at 38,084 hours.

Wage Estimate

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2019 National Occupational Employment and Wage Estimates for all salary estimates (http://www.bls.gov/oes/current/oes_nat.htm). In this regard, the following table presents the mean hourly wage, the cost of fringe benefits and overhead (calculated at 100 percent of salary), and the adjusted hourly wage.

Occupation Title	**Occupation Code**	**Mean Hourly Wage ($/hr)**	**Fringe Benefits and Overhead ($/hr)**	**Adjusted Hourly Wage ($/hr)**
Community and Social Service Occupations	21-0000	24.27	24.27	48.54

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

Burden Estimates

CMS estimates that each State will complete the collection of data and submission to CMS within 1 hour. There is a potential universe of 44 respondents that will submit 3-6 responses each. We also estimate to receive a total of 264 responses (44 respondents x 6 responses/respondent).

CMS expects that a Community and Social Service employee would need 1 hour at $48.54/hr to complete one pre-print. In aggregate, we estimate a burden of 264 hours (264 responses x 1 hr/response) at a cost of $12,815 (264 hr x $48.54/hr).

Since our time estimates remain unchanged, system limitations prevent the submission of zero burden. To compensate for the system limitations and to avoid unnecessary double counting, we are seeking approval of 5 hours (total).

Information Collection Instruments and Instruction/Guidance Documents

- Section 438.6(c) pre-print

Under §438.6(c)(2)(i), states must obtain written approval prior to implementation of the state-directed payment arrangement. The preprint will be used to meet the prior approval requirement.

- Section 438.6(c) pre-print Appendix K EXAMPLE

The example will be used by states seeking approval to implement state directed payments under 42 CFR 438.6(c) to contractually require managed care plans to make retainer payments to providers where the authorized service is covered under the contract. In order for states to seek approval under 42 CFR 438.6(c), the retainer payments must be authorized as part of the 1915(c) HCBS waiver, section 1115 demonstration waiver, or other CMS authority. Once the retainer payments are authorized under one of these authorities, a state directed payment preprint must be submitted to effectuate these retainer payments under a state's contract with its managed care plans. In order to facilitate CMS' expedited review and approval of these payments, CMS is making a prepopulated template available to states for minimum fee schedule requirements tied to approved retainer payments.

- Section 438.6(c) pre-print COVID19 EXAMPLE

The example will be used by states seeking approval to implement state directed payments under 42 CFR 438.6(c) to contractually require managed care plans to make specific payments to providers to help mitigate the impacts of the public health emergency. In order to help states comply with the regulatory requirements under 42 CFR 438.6(c) and to create a framework for states that can help facilitate CMS' review and approval process, our guidance provides guiding principles related to state directed payments developed in response to COVID-19. The regulations at 42 CFR 438.6(c)(2) also require that states have written approval from CMS prior to implementation of the state directed payments. CMS currently utilizes a preprint to implement the prior approval process that states must complete and submit to CMS for approval of the state directed payments. For states seeking to implement state directed payments to respond to this public health emergency, we are publishing a prepopulated version of the preprint to facilitate a more streamlined submission and review process.

- CIB: Medicaid Managed Care Options in Responding to COVID-19

The COVID-19 public health emergency is causing dramatic shifts in utilization across the healthcare industry, causing financial uncertainty for both healthcare providers and managed care

plans. Many states are now seeking ways to temporarily modify provider reimbursement methodologies and rates under their Medicaid managed care contracts to address costs and other impacts of the public health emergency while preserving systems of care and access to services for Medicaid beneficiaries. States already have the ability under existing CMS authorities to modify their managed care contracts and rates to incorporate many modifications that would help states respond to the ongoing public health emergency. This guidance outlines these approaches and will streamline CMS' review and approval processes related to these actions. Specifically, CMS is outlining our framework to provide flexibility appropriate to the public health emergency, while still maintaining alignment with statutory and regulatory requirements, including that managed care capitation rates must still be actuarially sound, and that payments under managed care contracts must still maintain linkages to utilization delivered under the contract. This guidance provides several specific options that states can consider (and already have authority to implement) under their Medicaid managed care contracts.

E. Timeline

n/a